Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VA Pittsburgh HCS, PA (VAMC Pittsburgh (HD) - 646A5 and VAMC Pittsburgh (UD) - 646)

VISN 4

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 1700

2. Point-in-time estimate of Veterans who are Chronically Homeless: 345

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **1700** (point-in-time estimate of homeless veterans in service area) **X 26%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 79%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 345** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were not homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	650	90
Transitional Housing Beds	748	85
Permanent Housing Beds	373	170

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 4

3. CHALENG Point of Contact Action Plan for FY 2005

Help with finding a job or getting employment	Refer veterans to VA VRS for assistance with development of resume, guidance to jobs, job fairs. Refer to Career Links. Refer to job fairs, assist with transportation through bus tickets or government vehicle.
Long-term, permanent housing	VA Healthcare for Homeless Veterans program will continue to work on housing programs through VA Grant and Per Diem. Advocate with VA Grant and Per Diem office for increased funding to VISN 3. Work with community agencies in locating available permanent housing.
Treatment for substance abuse	Educate veterans and community providers about VA resources for substance abuse treatment. VA Healthcare for Homeless Veterans clinicians will assist in linking veterans to treatment at VA programs. Collaborate with Allegheny County Homeless Alliance committee to plan and implement substance abuse treatment programs. Continue with follow-up by encouraging veterans to attend aftercare sessions, AA & NA meetings.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 43 Non-VA staff Participants: 52% Homeless/Formerly Homeless: 40%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Discharge upgrade	2.45	0%	2.90	15
2	Legal assistance	2.5	3%	2.61	4
3	Child care	2.55	7%	2.39	3
4	Welfare payments	2.7	0%	2.97	16
5	Family counseling	2.85	0%	2.85	12
6	Guardianship (financial)	2.85	0%	2.76	9
7	Eye care	2.86	0%	2.65	5
8	Help with finding a job or getting employment	2.86	33%	3.00	17
9	Long-term, permanent housing	2.87	17%	2.25	1
10	Dental care	2.89	7%	2.34	2
11	Women's health care	2.9	0%	3.09	21
12	Glasses	2.94	0%	2.67	6
13	SSI/SSD process	2.97	10%	3.02	19
14	Drop-in center or day program	3.03	0%	2.77	10
15	Help managing money	3.03	7%	2.71	7
16	Education	3.03	3%	2.88	13
17	Clothing	3.05	3%	3.40	31
18	Job training	3.06	14%	2.88	14
19	Help with transportation	3.06	7%	2.82	11
20	VA disability/pension	3.09	14%	3.33	29
21	Halfway house or transitional living facility	3.17	7%	2.76	8
22	Help getting needed documents or identification	3.19	0%	3.16	23
23	Treatment for dual diagnosis	3.22	0%	3.01	18
24	AIDS/HIV testing/counseling	3.24	3%	3.38	30
25	TB treatment	3.27	0%	3.45	33
26	Emergency (immediate) shelter	3.32	7%	3.04	20
27	Hepatitis C testing	3.49	7%	3.41	32
28	Detoxification from substances	3.51	7%	3.11	22
29	Services for emotional or psychiatric problems	3.51	7%	3.20	25
30	TB testing	3.53	0%	3.58	36
31	Spiritual	3.53	3%	3.30	27
32	Treatment for substance abuse	3.54	14%	3.30	28
33	Help with medication	3.56	0%	3.18	24
34	Food	3.68	3%	3.56	35
35	Personal hygiene (shower, haircut, etc.)	3.7	0%	3.21	26
36	Medical services	3.72	10%	3.55	34

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.67	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.5	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.21	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.39	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.97	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.21	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.94	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	4.03	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.56	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.46	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.37	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.73	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.16	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.12	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.42	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.56	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.17	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.96	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.19	1.84

Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2004 Survey: VAM&ROC Wilmington, DE - 460

VISN 4

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 500

2. Point-in-time estimate of Veterans who are Chronically Homeless: 20

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **500** (point-in-time estimate of homeless veterans in service area) **X 4%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 92%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 20** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	251	50
Transitional Housing Beds	108	31
Permanent Housing Beds	252	113

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	The homeless community providers are very concerned that this is a HUD priority, but federal funding is not growing to meet it. CHALENG POC will assist with support letters and data as requested.
Immediate shelter	A major concern is that resources for immediate shelter are not available in all counties and that restrictions (e.g., county residence requirement, criminal clearance) block certain individuals. We are committed to being mobile and able to move homeless veterans across county or state lines for shelter.
Treatment for substance abuse	Wilmington VAMC lacks any inpatient behavioral health (no detox, acute psych beds, substance abuse inpatient). Homeless veterans lacking any health coverage are caught in state and local systems offering disjointed coverage. We are committed to being mobile and cross state lines to get veterans to VA substance abuse and psychiatric treatment.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 14 Non-VA staff Participants: 86%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	1.79	57%	2.25	1
2	Guardianship (financial)	2.31	14%	2.76	9
3	Halfway house or transitional living facility	2.36	21%	2.76	8
4	Child care	2.36	0%	2.39	3
5	Glasses	2.43	0%	2.67	6
6	Help managing money	2.5	0%	2.71	7
7	Eye care	2.57	7%	2.65	5
8	Drop-in center or day program	2.69	7%	2.77	10
9	Dental care	2.71	7%	2.34	2
10	SSI/SSD process	2.77	0%	3.02	19
11	Job training	2.77	0%	2.88	14
12	Family counseling	2.83	0%	2.85	12
13	Education	2.85	0%	2.88	13
14	Legal assistance	2.85	0%	2.61	4
15	Help with finding a job or getting employment	2.92	0%	3.00	17
16	Personal hygiene (shower, haircut, etc.)	3	0%	3.21	26
17	Services for emotional or psychiatric problems	3	14%	3.20	25
18	Discharge upgrade	3	0%	2.90	15
19	Spiritual	3	0%	3.30	27
20	Emergency (immediate) shelter	3.07	21%	3.04	20
21	Help getting needed documents or identification	3.08	0%	3.16	23
22	Help with transportation	3.14	7%	2.82	11
23	Treatment for dual diagnosis	3.15	7%	3.01	18
24	TB treatment	3.21	0%	3.45	33
25	Welfare payments	3.23	0%	2.97	16
26	Women's health care	3.29	0%	3.09	21
27	Hepatitis C testing	3.29	0%	3.41	32
28	Detoxification from substances	3.43	14%	3.11	22
29	Treatment for substance abuse	3.5	14%	3.30	28
30	Help with medication	3.5	0%	3.18	24
31	VA disability/pension	3.54	0%	3.33	29
32	Clothing	3.57	0%	3.40	31
33	TB testing	3.57	0%	3.58	36
34	AIDS/HIV testing/counseling	3.64	0%	3.38	30
35	Food	3.71	0%	3.56	35
36	Medical services	3.79	7%	3.55	34

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.86	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.93	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.43	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.43	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.5	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.29	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.29	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	4.08	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.25	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.33	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.83	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.5	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.5	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.55	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.92	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.58	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.75	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.64	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.08	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.08	1.84

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CHALENG 2004 Survey: VAMC Altoona, PA - 503

VISN 4

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 1

2. Point-in-time estimate of Veterans who are Chronically Homeless: 0

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **1** (point-in-time estimate of homeless veterans in service area) **X 7%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 60%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 0** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	370	0
Transitional Housing Beds	10	0
Permanent Housing Beds	30	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Continue to work with local agencies to develop another shelter for men in Altoona.
Transitional living facility	Work with local agencies to create safe place for the homeless person until a more permanent plan can be made with the person and to assist with substance abuse issues.
Long-term, permanent housing	Organize a meeting with local community agencies to find funding to provide permanent housing.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 49 Non-VA staff Participants: 90%
Homeless/Formerly Homeless: 4%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Drop-in center or day program	2.77	5%	2.77	10
2	Dental care	2.79	16%	2.34	2
3	Long-term, permanent housing	2.84	16%	2.25	1
4	Halfway house or transitional living facility	2.89	13%	2.76	8
5	Help managing money	2.92	0%	2.71	7
6	Child care	2.92	3%	2.39	3
7	Legal assistance	2.92	3%	2.61	4
8	Detoxification from substances	2.95	0%	3.11	22
9	Treatment for dual diagnosis	3	3%	3.01	18
10	Glasses	3	0%	2.67	6
11	Eye care	3.03	0%	2.65	5
12	AIDS/HIV testing/counseling	3.05	0%	3.38	30
13	Personal hygiene (shower, haircut, etc.)	3.07	5%	3.21	26
14	TB treatment	3.08	3%	3.45	33
15	Guardianship (financial)	3.08	0%	2.76	9
16	Emergency (immediate) shelter	3.09	39%	3.04	20
17	Treatment for substance abuse	3.14	11%	3.30	28
18	Family counseling	3.17	0%	2.85	12
19	Services for emotional or psychiatric problems	3.18	3%	3.20	25
20	TB testing	3.21	3%	3.58	36
21	Women's health care	3.23	0%	3.09	21
22	Help with medication	3.24	3%	3.18	24
23	Discharge upgrade	3.32	0%	2.90	15
24	Job training	3.33	13%	2.88	14
25	Food	3.35	3%	3.56	35
26	Clothing	3.35	5%	3.40	31
27	Help with transportation	3.37	8%	2.82	11
28	Education	3.37	3%	2.88	13
29	Hepatitis C testing	3.38	3%	3.41	32
30	Help with finding a job or getting employment	3.39	24%	3.00	17
31	Help getting needed documents or identification	3.45	5%	3.16	23
32	Medical services	3.55	8%	3.55	34
33	Spiritual	3.55	5%	3.30	27
34	SSI/SSD process	3.59	0%	3.02	19
35	Welfare payments	3.62	0%	2.97	16
36	VA disability/pension	3.66	3%	3.33	29

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.4	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.23	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.95	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.19	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.08	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.02	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.82	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.75	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.26	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.82	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.03	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.38	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.84	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.58	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.66	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.94	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.53	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.71	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.78	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.67	1.84

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CHALENG 2004 Survey: VAMC Butler, PA - 529

VISN 4

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 51

2. Point-in-time estimate of Veterans who are Chronically Homeless: <DATA NOT AVAILABLE>

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **51** (point-in-time estimate of homeless veterans in service area) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who had a mental health or substance abuse disorder) **= <DATA NOT AVAILABLE>** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	6	5
Transitional Housing Beds	10	0
Permanent Housing Beds	5	2

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Will continue to work with the community to address the need for emergency shelter.
Long-term, permanent housing	A permanent house program "The Hope Project," will begin filling 18 apartments throughout Butler City. This program is for chronically homeless and mentally ill. The need continues for more programs like this. Will continue to work with agencies on this need.
Help with Transportation	The community is aware of this need. There is a continuous conversation and people are starting to listen, but no plans as of yet.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 70 Non-VA staff Participants: 79%
Homeless/Formerly Homeless: 7%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Child care	2.94	2%	2.39	3
2	Personal hygiene (shower, haircut, etc.)	2.96	7%	3.21	26
3	Long-term, permanent housing	2.98	25%	2.25	1
4	Legal assistance	3.04	0%	2.61	4
5	Emergency (immediate) shelter	3.08	30%	3.04	20
6	Help with transportation	3.1	16%	2.82	11
7	Discharge upgrade	3.15	0%	2.90	15
8	Dental care	3.23	2%	2.34	2
9	Drop-in center or day program	3.3	0%	2.77	10
10	Eye care	3.3	0%	2.65	5
11	Help managing money	3.3	5%	2.71	7
12	Education	3.36	5%	2.88	13
13	Guardianship (financial)	3.39	5%	2.76	9
14	Glasses	3.41	0%	2.67	6
15	Clothing	3.42	2%	3.40	31
16	Hepatitis C testing	3.48	2%	3.41	32
17	Treatment for dual diagnosis	3.5	2%	3.01	18
18	Spiritual	3.51	2%	3.30	27
19	Detoxification from substances	3.52	14%	3.11	22
20	Help with medication	3.53	2%	3.18	24
21	SSI/SSD process	3.53	2%	3.02	19
22	Job training	3.53	12%	2.88	14
23	Halfway house or transitional living facility	3.54	12%	2.76	8
24	AIDS/HIV testing/counseling	3.54	0%	3.38	30
25	Family counseling	3.56	7%	2.85	12
26	Help getting needed documents or identification	3.56	2%	3.16	23
27	Food	3.58	9%	3.56	35
28	Women's health care	3.59	0%	3.09	21
29	Help with finding a job or getting employment	3.68	14%	3.00	17
30	TB treatment	3.69	0%	3.45	33
31	TB testing	3.7	0%	3.58	36
32	Treatment for substance abuse	3.71	5%	3.30	28
33	VA disability/pension	3.73	7%	3.33	29
34	Welfare payments	3.75	2%	2.97	16
35	Services for emotional or psychiatric problems	3.8	2%	3.20	25
36	Medical services	4.02	7%	3.55	34

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.87	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.78	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.36	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.29	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.23	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.18	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.13	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.96	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.67	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.3	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.19	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.8	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.88	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.22	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.14	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.51	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.08	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.92	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.89	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.14	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Clarksburg, WV - 540

VISN 4

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 12

2. Point-in-time estimate of Veterans who are Chronically Homeless: 1

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **12** (point-in-time estimate of homeless veterans in service area) **X 17%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 70%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 1** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	37	10
Transitional Housing Beds	1	10
Permanent Housing Beds	60	10

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 4

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility	Continue to work with local coalitions, shelters and HUD Continuum of Care to try to start more transitional living facilities. Also, continue to work with West Virginia Mental Health Consumers Association.
Long-term, permanent housing	Continue to work with HUD and landlords to seek affordable, adequate housing.
Clothing	Continue to provide veterans with suitable clothing along with teaching good hygiene.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 29 Non-VA staff Participants: 88%
Homeless/Formerly Homeless: 10%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Legal assistance	2	0%	2.61	4
2	Child care	2.16	0%	2.39	3
3	Guardianship (financial)	2.22	5%	2.76	9
4	Dental care	2.24	10%	2.34	2
5	Long-term, permanent housing	2.45	29%	2.25	1
6	Drop-in center or day program	2.47	10%	2.77	10
7	Halfway house or transitional living facility	2.5	38%	2.76	8
8	Family counseling	2.53	0%	2.85	12
9	Education	2.58	10%	2.88	13
10	Detoxification from substances	2.63	0%	3.11	22
11	Welfare payments	2.63	0%	2.97	16
12	Job training	2.63	0%	2.88	14
13	Treatment for dual diagnosis	2.65	5%	3.01	18
14	Help managing money	2.74	0%	2.71	7
15	AIDS/HIV testing/counseling	2.83	0%	3.38	30
16	TB treatment	2.83	0%	3.45	33
17	Glasses	2.85	0%	2.67	6
18	Spiritual	2.88	19%	3.30	27
19	Discharge upgrade	2.94	0%	2.90	15
20	Help with medication	2.95	5%	3.18	24
21	Eye care	2.95	5%	2.65	5
22	Help with finding a job or getting employment	2.95	5%	3.00	17
23	Treatment for substance abuse	3	0%	3.30	28
24	Women's health care	3	0%	3.09	21
25	Services for emotional or psychiatric problems	3.05	0%	3.20	25
26	SSI/SSD process	3.05	0%	3.02	19
27	Help getting needed documents or identification	3.1	0%	3.16	23
28	TB testing	3.11	0%	3.58	36
29	Help with transportation	3.26	5%	2.82	11
30	Hepatitis C testing	3.32	0%	3.41	32
31	Medical services	3.4	10%	3.55	34
32	Personal hygiene (shower, haircut, etc.)	3.62	5%	3.21	26
33	VA disability/pension	3.65	14%	3.33	29
34	Clothing	3.7	23%	3.40	31
35	Food	3.81	24%	3.56	35
36	Emergency (immediate) shelter	3.95	5%	3.04	20

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.88	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.27	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.96	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.68	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.68	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.58	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.46	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.04	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.68	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.3	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.28	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.47	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.75	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.7	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.25	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.37	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.05	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.89	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.95	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.26	1.84

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CHALENG 2004 Survey: VAMC Coatesville - 542

VISN 4

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 997

2. Point-in-time estimate of Veterans who are Chronically Homeless: 181

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **997** (point-in-time estimate of homeless veterans in service area) **X 22%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 85%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 181** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	2082	100
Transitional Housing Beds	589	100
Permanent Housing Beds	301	200

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	VA will continue its commitment from the last four years to provide a full range of outpatient services for any veterans residing in permanent housing through nonprofit and HUD housing programs. Staff will also educate and encourage participation in all HUD housing programs.
Dental Care	VA along with other agencies will continue to communicate about low-cost community dental programs and make appropriate referrals (e.g., community volunteers in medicine, university training programs, etc.).
Help with Transportation	All agencies will attempt to expand use of existing transportation programs including Impact Services van, Philadelphia Veterans Multi-Service and Education Center Van, DAV transportation van services, and VA work restoration programs.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 57 Non-VA staff Participants: 49%
Homeless/Formerly Homeless: 9%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Child care	2.43	4%	2.39	3
2	Long-term, permanent housing	2.65	40%	2.25	1
3	Dental care	2.69	17%	2.34	2
4	Guardianship (financial)	2.85	6%	2.76	9
5	Glasses	2.96	2%	2.67	6
6	Legal assistance	3.02	9%	2.61	4
7	Eye care	3.05	9%	2.65	5
8	Help with transportation	3.06	2%	2.82	11
9	Family counseling	3.08	6%	2.85	12
10	Help managing money	3.1	6%	2.71	7
11	Halfway house or transitional living facility	3.19	28%	2.76	8
12	Women's health care	3.25	2%	3.09	21
13	Welfare payments	3.3	0%	2.97	16
14	Education	3.3	6%	2.88	13
15	SSI/SSD process	3.43	2%	3.02	19
16	Discharge upgrade	3.46	0%	2.90	15
17	Job training	3.5	13%	2.88	14
18	Treatment for dual diagnosis	3.51	4%	3.01	18
19	Services for emotional or psychiatric problems	3.57	6%	3.20	25
20	Drop-in center or day program	3.68	2%	2.77	10
21	Emergency (immediate) shelter	3.7	11%	3.04	20
22	Help with medication	3.73	6%	3.18	24
23	Spiritual	3.73	2%	3.30	27
24	Help getting needed documents or identification	3.76	0%	3.16	23
25	Personal hygiene (shower, haircut, etc.)	3.78	0%	3.21	26
26	VA disability/pension	3.78	0%	3.33	29
27	Help with finding a job or getting employment	3.81	6%	3.00	17
28	TB treatment	3.88	0%	3.45	33
29	Medical services	3.93	2%	3.55	34
30	Detoxification from substances	3.94	2%	3.11	22
31	Clothing	3.96	2%	3.40	31
32	AIDS/HIV testing/counseling	3.98	0%	3.38	30
33	TB testing	3.98	0%	3.58	36
34	Hepatitis C testing	4.08	0%	3.41	32
35	Treatment for substance abuse	4.19	4%	3.30	28
36	Food	4.4	2%	3.56	35

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.83	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.44	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.02	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.1	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.73	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.88	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.71	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.84	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.59	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.5	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.15	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.73	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.7	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.88	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.88	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.27	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.97	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.77	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.78	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.94	1.84

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CHALENG 2004 Survey: VAMC Erie, PA - 562

VISN 4

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 20

2. Point-in-time estimate of Veterans who are Chronically Homeless: 4

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **20** (point-in-time estimate of homeless veterans in service area) **X 28%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 79%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 4** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	178	0
Transitional Housing Beds	10	2
Permanent Housing Beds	22	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 5

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Develop a continuity among all temporary shelters that provides common requirements; thus reducing problems of entry due to different admission requirements.
Treatment for substance abuse	Work on educating local agencies on various requirements to receive substance abuse services. Help establish programs that involve local agencies and resources.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 20 Non-VA staff Participants: 85%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Child care	2.44	0%	2.39	3
2	Dental care	2.61	11%	2.34	2
3	Long-term, permanent housing	2.72	47%	2.25	1
4	Eye care	2.76	0%	2.65	5
5	Glasses	2.83	5%	2.67	6
6	Legal assistance	2.94	5%	2.61	4
7	Guardianship (financial)	3.06	0%	2.76	9
8	Help managing money	3.11	11%	2.71	7
9	Job training	3.17	5%	2.88	14
10	Spiritual	3.18	0%	3.30	27
11	Help with finding a job or getting employment	3.28	0%	3.00	17
12	Education	3.39	0%	2.88	13
13	Women's health care	3.41	5%	3.09	21
14	Help with transportation	3.44	0%	2.82	11
15	Welfare payments	3.5	0%	2.97	16
16	Family counseling	3.56	5%	2.85	12
17	Help with medication	3.58	11%	3.18	24
18	Discharge upgrade	3.59	0%	2.90	15
19	Personal hygiene (shower, haircut, etc.)	3.61	0%	3.21	26
20	VA disability/pension	3.67	0%	3.33	29
21	Detoxification from substances	3.72	11%	3.11	22
22	Treatment for dual diagnosis	3.72	0%	3.01	18
23	AIDS/HIV testing/counseling	3.74	0%	3.38	30
24	Hepatitis C testing	3.78	0%	3.41	32
25	SSI/SSD process	3.78	0%	3.02	19
26	TB treatment	3.83	0%	3.45	33
27	Drop-in center or day program	3.89	0%	2.77	10
28	Treatment for substance abuse	3.94	21%	3.30	28
29	Food	4	0%	3.56	35
30	Clothing	4	0%	3.40	31
31	Services for emotional or psychiatric problems	4	0%	3.20	25
32	Emergency (immediate) shelter	4.05	26%	3.04	20
33	TB testing	4.11	0%	3.58	36
34	Halfway house or transitional living facility	4.17	26%	2.76	8
35	Help getting needed documents or identification	4.22	5%	3.16	23
36	Medical services	4.37	5%	3.55	34

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.7	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.4	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.5	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.4	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.25	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.9	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.16	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.61	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.78	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.71	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.83	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.28	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.63	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.94	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.35	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.94	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.88	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.35	1.84

Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2004 Survey: VAMC Lebanon, PA - 595

VISN 4

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 163

2. Point-in-time estimate of Veterans who are Chronically Homeless: 35

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **163** (point-in-time estimate of homeless veterans in service area) **X 24%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 89%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 35** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	325	36
Transitional Housing Beds	336	65
Permanent Housing Beds	245	239

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 5

3. CHALENG Point of Contact Action Plan for FY 2005

Dental Care	Continue to utilize and expand existing resources. Coalition sub-committees for social services will continue action planning.
Long-term, permanent housing	Local coalitions to apply for HUD Continuum of Care, state, and county funding to maintain and expand affordable permanent housing units.
Eye Care	Coalition social services subcommittees will continue to form action planning to address need. Continue to utilize and expand existing eye care resources.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 48 Non-VA staff Participants: 89%
Homeless/Formerly Homeless: 4%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Dental care	2.37	28%	2.34	2
2	Eye care	2.52	11%	2.65	5
3	Help with transportation	2.55	19%	2.82	11
4	Long-term, permanent housing	2.59	25%	2.25	1
5	Glasses	2.64	3%	2.67	6
6	Legal assistance	2.75	6%	2.61	4
7	Child care	2.78	0%	2.39	3
8	Guardianship (financial)	2.88	3%	2.76	9
9	Help managing money	2.88	3%	2.71	7
10	Family counseling	2.93	0%	2.85	12
11	Drop-in center or day program	2.95	0%	2.77	10
12	Help with medication	2.96	6%	3.18	24
13	Emergency (immediate) shelter	2.98	17%	3.04	20
14	Halfway house or transitional living facility	2.98	14%	2.76	8
15	Job training	3.02	6%	2.88	14
16	Education	3.02	0%	2.88	13
17	Help with finding a job or getting employment	3.07	3%	3.00	17
18	Help getting needed documents or identification	3.1	0%	3.16	23
19	Women's health care	3.12	0%	3.09	21
20	Personal hygiene (shower, haircut, etc.)	3.18	3%	3.21	26
21	Discharge upgrade	3.24	0%	2.90	15
22	Treatment for dual diagnosis	3.26	3%	3.01	18
23	Services for emotional or psychiatric problems	3.32	6%	3.20	25
24	Spiritual	3.37	3%	3.30	27
25	Welfare payments	3.39	0%	2.97	16
26	SSI/SSD process	3.45	3%	3.02	19
27	VA disability/pension	3.46	3%	3.33	29
28	Detoxification from substances	3.49	6%	3.11	22
29	TB treatment	3.49	0%	3.45	33
30	TB testing	3.5	0%	3.58	36
31	AIDS/HIV testing/counseling	3.51	3%	3.38	30
32	Hepatitis C testing	3.51	3%	3.41	32
33	Medical services	3.52	6%	3.55	34
34	Treatment for substance abuse	3.57	6%	3.30	28
35	Clothing	3.65	6%	3.40	31
36	Food	3.72	14%	3.56	35

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.58	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.36	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.63	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.72	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.57	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.6	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.42	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.4	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.19	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.85	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.86	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.71	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.41	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.35	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.55	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.69	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.56	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.69	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.48	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.72	1.84

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CHALENG 2004 Survey: VAMC Philadelphia, PA - 642

VISN 4

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 700

2. Point-in-time estimate of Veterans who are Chronically Homeless: 184

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **700** (point-in-time estimate of homeless veterans in service area) **X 30%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 88%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 184** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	2500	30
Transitional Housing Beds	79	0
Permanent Housing Beds	50	35

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 55

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Develop increased relationship with community providers to develop leases for permanent housing.
SSI/SSD process	Promote better relationship with Social Security Administration to increase communication and respond to requests for incapacitation to manage funds. They are difficult to work with. Rarely return calls. They need to improve staffing for guardianship services.
Help Managing Money	Better relationship with SSA to increase communication and respond to requests for incapacitation to manage funds. They need to improve staffing for guardianship services.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 42 Non-VA staff Participants: 50%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	1.92	48%	2.25	1
2	Dental care	2.08	25%	2.34	2
3	Child care	2.19	0%	2.39	3
4	Eye care	2.33	0%	2.65	5
5	Glasses	2.38	0%	2.67	6
6	Job training	2.45	8%	2.88	14
7	Legal assistance	2.5	3%	2.61	4
8	Guardianship (financial)	2.53	3%	2.76	9
9	Help managing money	2.56	5%	2.71	7
10	Help with finding a job or getting employment	2.63	13%	3.00	17
11	Halfway house or transitional living facility	2.64	30%	2.76	8
12	Family counseling	2.69	0%	2.85	12
13	Help with transportation	2.79	5%	2.82	11
14	Discharge upgrade	2.79	0%	2.90	15
15	Education	2.85	0%	2.88	13
16	SSI/SSD process	2.87	3%	3.02	19
17	Spiritual	2.87	3%	3.30	27
18	Emergency (immediate) shelter	2.95	15%	3.04	20
19	Personal hygiene (shower, haircut, etc.)	3	0%	3.21	26
20	Clothing	3.11	3%	3.40	31
21	Welfare payments	3.11	3%	2.97	16
22	Help getting needed documents or identification	3.11	3%	3.16	23
23	Treatment for dual diagnosis	3.18	0%	3.01	18
24	Help with medication	3.21	0%	3.18	24
25	Detoxification from substances	3.26	5%	3.11	22
26	Women's health care	3.27	3%	3.09	21
27	Food	3.28	5%	3.56	35
28	Treatment for substance abuse	3.33	10%	3.30	28
29	VA disability/pension	3.38	3%	3.33	29
30	Services for emotional or psychiatric problems	3.39	5%	3.20	25
31	TB treatment	3.43	0%	3.45	33
32	Medical services	3.46	3%	3.55	34
33	TB testing	3.46	0%	3.58	36
34	Hepatitis C testing	3.5	0%	3.41	32
35	Drop-in center or day program	3.64	0%	2.77	10
36	AIDS/HIV testing/counseling	3.83	0%	3.38	30

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.54	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.17	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.76	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.26	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.74	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.94	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.66	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.74	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.76	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.42	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.12	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.42	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.76	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.8	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.88	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.12	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.88	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.72	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.72	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.72	1.84

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CHALENG 2004 Survey: VAMC Wilkes-Barre, PA - 693

VISN 4

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 6

2. Point-in-time estimate of Veterans who are Chronically Homeless: 0

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **6** (point-in-time estimate of homeless veterans in service area) **X 7%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 88%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 0** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	160	0
Transitional Housing Beds	35	0
Permanent Housing Beds	40	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Job Training	Hired a CWT (Compensated Work Therapy) coordinator in FY 2004. New CWT coordinator to become familiar with community resources, and agencies which will hire homeless veterans.
Legal Assistance	Solicit community for legal advisors willing to work pro bono. Utilize existing legal services.
Long-term, permanent housing	Strengthen links with local community agencies: private landlords to ensure more permanent housing for the homeless.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 28 Non-VA staff Participants: 89% Homeless/Formerly Homeless: 11%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Education	3.08	31%	2.88	13
2	Child care	3.28	0%	2.39	3
3	Help with transportation	3.31	19%	2.82	11
4	Dental care	3.35	4%	2.34	2
5	Long-term, permanent housing	3.5	15%	2.25	1
6	Glasses	3.54	0%	2.67	6
7	Guardianship (financial)	3.54	4%	2.76	9
8	Help managing money	3.56	12%	2.71	7
9	Legal assistance	3.58	0%	2.61	4
10	Halfway house or transitional living facility	3.62	15%	2.76	8
11	Eye care	3.62	0%	2.65	5
12	Discharge upgrade	3.62	0%	2.90	15
13	Help with medication	3.65	0%	3.18	24
14	Job training	3.65	31%	2.88	14
15	Spiritual	3.65	0%	3.30	27
16	Family counseling	3.68	0%	2.85	12
17	Hepatitis C testing	3.7	8%	3.41	32
18	Drop-in center or day program	3.72	0%	2.77	10
19	Treatment for dual diagnosis	3.73	0%	3.01	18
20	Help with finding a job or getting employment	3.76	4%	3.00	17
21	Women's health care	3.79	8%	3.09	21
22	Services for emotional or psychiatric problems	3.81	8%	3.20	25
23	Help getting needed documents or identification	3.84	0%	3.16	23
24	TB treatment	3.85	0%	3.45	33
25	SSI/SSD process	3.88	0%	3.02	19
26	Emergency (immediate) shelter	3.89	19%	3.04	20
27	TB testing	3.92	8%	3.58	36
28	Personal hygiene (shower, haircut, etc.)	3.96	0%	3.21	26
29	Detoxification from substances	4.07	4%	3.11	22
30	Treatment for substance abuse	4.07	0%	3.30	28
31	VA disability/pension	4.07	0%	3.33	29
32	AIDS/HIV testing/counseling	4.08	0%	3.38	30
33	Welfare payments	4.08	0%	2.97	16
34	Clothing	4.24	0%	3.40	31
35	Medical services	4.41	12%	3.55	34
36	Food	4.58	0%	3.56	35

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.38	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	4.12	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.58	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.58	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.62	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.54	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.58	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	4.42	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.27	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.24	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.21	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.87	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.91	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.86	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.22	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.74	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.14	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.78	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.23	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.52	1.84